

醫療 / 住院現金索償表格

Medical / Hospital Cash Claim Form

(只供蘇黎世保險直屬營業部之個人客戶專用 For Zurich agency division personal customers ONLY)

為使敝公司能迅速地處理貴保戶之賠償申請，請於就醫後 30 日內填妥此表格及連同有關單據一併交回。
In order to assist us in processing your claim promptly, please complete and return this form together with the original receipts / invoices within 30 days after receiving treatment.

- Whole Life Hospital Cash Insurance Plan. Please call 2535 3502 for enquiry or fax to 2105 3403.
「保一世」住院現金保障計劃。任何查詢，請致電 2535 3502 或 傳真致 2105 3403。
- Hospital Cash Insurance, Hospital & Surgery Expenses Insurance. Please call 2903 9388 for enquiry or fax to 2968 1660.
住院現金保障，住院及手術保障。任何查詢，請致電 2903 9388 或 傳真致 2968 1660。

所有問題均須由受保人或其監護人作答
All questions must be answered by insured person or the guardian

保單號碼
Policy no. _____

1. 保戶資料

保戶姓名
Name of insured _____

病人姓名
Name of patient _____

地址
Address _____

身份證號碼
Identity card no. _____

病人職業
Occupation of patient _____

與保戶關係
Relationship with insured _____

電郵地址 (非必須填寫)
Email address (Optional) _____

聯絡電話
Telephone no. _____

2. 住院詳情

Details of the hospitalization

(a) 醫院名稱
Name of hospital _____

(b) 入院日期
Date of admission _____

(c) 主診醫生姓名
Name of the attending doctor(s) _____

3. 閣下是否正就此次住院申領其他賠償

Are you making any other insurance or compensation claim as a result of this hospitalization
() 否 No () 是 Yes 若是，請提供以下資料 If yes, please provide the information below

保單號碼 Policy no.	保險公司名稱 Name of insurance company	保障類別 (如: 醫療費用 / 住院現金) Type of insurance (eg. medical expenses / hospital cash)
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. 若住院由疾病導致

If hospitalization was due to illness:

(a) 病人之病徵
Describe the patient's symptoms _____

(b) 入院前多久此病徵才被發現
How long had the patient been having these symptoms before admission into hospital _____

請詳述 Give details of	日期 Date	醫生姓名地址及電話 Name(s), address(es) and telephone no.(s)
(i) 此症之首位主診醫生 the doctor first consulted for this illness	_____	_____
(ii) 轉介往醫院之醫生 the doctors who referred the patient to hospital	_____	_____
(iii) 診治病人之其他醫生 all other doctors consulted during this illness	_____	_____
(iv) 過去五年內所有醫生 all other doctors consulted during the past five years	_____	_____

Private & Confidential 私人及保密文件

5. 若住院由意外導致

If hospitalization was due to accident

(a) 意外何時發生

When did it happen

日期

Date: _____

時間

Time: _____

(b) 意外地點

Where did it happen _____

(c) 請述意外經過

Describe how it happened

(d) 請述受傷情況

Describe the injuries

(e) 曾到何警署報案

Police station to which the accident was reported _____

(f) 檔案編號

Police reference no _____

6. 其他

Others

索償程序完成後, 閣下是否需要退回已遞交之有關文件

I request to return the submitted claim document(s) upon completed the claim procedure

() 否 No

如是, 請選擇

() 正本之醫療單據

() 醫療報告

If yes, please tick () original medical receipts

() Medical report

索償文件

請填妥本索償表並提交以下所需證明文件(正本), 如適用, 寄回本公司以便處理閣下之賠償事宜

(1) 住院索償:

醫療賬單詳列:

各項費用, 病人姓名, 留院日期

(2) 所有主診醫生/專科醫生/麻醉師/外科醫生/物理治療師之賬單詳列:

病人姓名, 求診日期, 診斷證明及/或治療紀錄, 醫療報告, 各項費用

(3) 手術後/住院後之覆診費:

醫生賬單詳列:

病人姓名, 求診日期, 診斷證明及/或治療紀錄, 費用

Claim documentation

Please complete and return this claim form together with the following documents (original copy), if appropriate, for our handling:

(a) Hospitalization

Hospital statement showing:

Itemized charges, name of the patient, period of confinement

(b) Receipt(s) of all attending doctors/specialists/anesthesiologist/surgeons/physiotherapists showing:

Name of the patient, date of consultation, diagnosis and/or treatment given, medical report(s), amount charged

(c) Post surgery / post hospitalization out-patient

Doctor's receipt showing:

Name of the patient, date of consultation, diagnosis and/or treatment given, amount charged

Payment Details (付款資料):

在保單條款許可的情況下, 閣下可選擇以支票或銀行轉帳方式收取賠償款項。

Subject to policy liability, you are given an option for settlement by claims cheque or by direct credit.

By cheque 支票

By direct credit/ wire transfer 銀行轉帳 (只適用於以下列出之銀行及少於港幣貳萬元之賠償 limited to listed banks below and for claim less than HKD20,000)

如閣下選擇銀行轉帳, 請提供相關銀行資料。此服務必須得到銀行安排下進行。本公司特此聲明, 上述要求並不代表閣下之索賠現正獲成功審批。有關決定, 本公司在收妥全部證明文件後, 將根據保單一切條款才作最後審批。敬請留意。

Please provide your banking details if you prefer payment by direct credit. However this is subject to the bank's arrangement. Furthermore, the supply of any information or documents under this section is not construed as an admission of liability under your policy. We hereby reserve all our rights for assessing your claim subject to terms and conditions of your policy.

戶口持有人姓名 (必須與保單持有人相同) Account Holder's Name (Must be the same as the Policyholder): _____

銀行名稱: 匯豐銀行 The Hongkong and Shanghai Banking Corporation Limited 渣打銀行 Standard Chartered Bank

Bank Name: 中國銀行(香港) Bank of China (Hong Kong)

恆生銀行 Hang Seng Bank

銀行帳戶號碼

Bank A/C No. _____

戶口持有人簽署

Signature of Account Holder: _____

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聲明及授權

Declaration and authorization

For Whole Life Hospital Cash Insurance Plan, please refer to Part 1 of the "Declaration and Authorization".

有關「保一世」住院現金保障計劃，請參照本表格“聲明及授權”之第一部分。

For Hospital Cash, Hospital & Surgery Expenses Insurance Plan, please refer to Part 2 of the "Declaration and Authorization".

有關住院現金，住院及手術保障，請參照本表格“聲明及授權”之第二部分。

Part 1

I declare that the answers given above are true and complete to the best of my knowledge and belief.

I hereby authorize any employers, hospital, physician, insurance company or other organization or person who has any records or knowledge with reference to the accident or the health and medical history of the patient, to give such information to Zurich Life Insurance Company Limited or its agents. A photocopy of this authorization shall be considered as effective and valid as the original. By signing below, I, for the purpose of the Personal Data (Privacy) Ordinance, agree that the personal information collected or held by Zurich Life Insurance Company Limited (whether contained in this form or otherwise obtained) or its agents to utilize the copy of my identification or may be used by or disclosed to any individual or organization within or outside of Hong Kong for the purposes of insurance or reinsurance related business including claim processing, investigation, account collection and litigation.

本人謹此聲明，以上所填報之資料及所列各項之事件乃屬完全真確並無對保險公司作任何資料之保留。

本人授權任何僱主、醫院、醫生、醫務人員、保險公司等任何有關人士或組織而持有本人有關意外，身體狀況和醫療紀錄等資料，可以將該等資料提供貴公司或其代理人，此授權書之影印本亦屬有效。

為符合個人資料(私隱)條例，從以下簽署，本人同意由蘇黎世人壽保險有限公司或其代理人所收集或持有的個人資料包括使用本人之身份證明文件副本，不論包含在這報告表或以其他方式獲取，均可供貴公司使用或向在香港境內或境外之任何人或機構披露作其保險或再保有關事項包括處理索償，調查，收集客戶資料和訴訟。

Part 2

I declare that the answers given above are true and complete to the best of my knowledge and belief.

I hereby authorize any employers, hospital, physician, insurance company or other organization or person who has any records or knowledge with reference to the accident or the health and medical history of the patient, to give such information to Zurich Insurance Company Limited or its agents. A photocopy of this authorization shall be considered as effective and valid as the original. By signing below, I, for the purpose of the Personal Data (Privacy) Ordinance, agree that the personal information collected or held by Zurich Insurance Company (whether contained in this form or otherwise obtained) or its agents to utilize the copy of my identification or may be used by or disclosed to any individual or organization within or outside of Hong Kong for the purposes of insurance or reinsurance related business including claim processing, investigation, account collection and litigation.

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Signature of policy holder 保單持有人簽署

Signature of patient 病人(受保人)簽署

Date 日期

Name of policy holder 保單持有人姓名

Name of patient 病人(受保人)姓名

HKID Card no / 香港身份證號碼

Passport no 或護照號碼

HKID Card no / 香港身份證號碼

Passport no 或護照號碼

蘇黎世人壽保險有限公司

理賠部(人壽業務): 香港港島東華蘭路 18 號港島東中心 24 - 27 樓

電話: 2535 3502 圖文傳真: 2105 3403

Zurich Life Insurance Company Limited

Life Claims Dept.: 24-27/F, One Island East, 18 Westlands Road, Island East, Hong Kong

Tel: 2535 3502 Fax: 2105 3403

蘇黎世保險有限公司(於瑞士註冊成立之公司)

理賠部: 香港港島東華蘭路 18 號港島東中心 24 - 27 樓

電話: 29039388 圖文傳真: 29681660

Zurich Insurance Company Limited (a company incorporated in Switzerland)

Claims dept.: 24-27/F, One Island East, 18 Westlands Road, Island East, Hong Kong

Tel: 29039388 Fax: 29681660

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由主診醫生填寫，有關費用由索償者支付

To be completed by the attending physician / surgeon at the claimant's own expense

Please complete in block letters

Name of patient _____	Identity card no _____
Date of admission _____	Date of discharge _____
Name of hospital _____	

(1) Clinical history of this patient:

(a) Date on which the patient first consulted you relating to this medical condition(s)/injury _____

(b) If caused by injury, please describe the cause and extent of injury _____

(c) Symptoms and complaints for this hospitalization/treatment _____

(d) Underlying cause(s) of the hospitalization _____

(e) According to the medical history given by the patient, how long had he/she been experiencing these symptoms before the first consultation and the date of the first consultation? _____

(f) How long, in your opinion, has the patient been suffering from this illness/injury? _____

(g) Was the patient confined in an Intensive Care Unit during this hospitalization or did he/she suffer from 3rd or 4th degree of burning? If yes, please indicate the period/numbers of days stayed _____

(2) Hospitalization history of this patient:

(a) Final diagnosis _____

(b) Date of operation _____
Operational procedure(s) performed _____

(c) If you have consulted other doctor during this hospitalization, please provide the following:
Consulted doctor's name _____ Reason _____
What treatment(s) had the doctor performed _____

(d) Please give brief discharge summary (including onset and duration of signs and symptoms/disease, etiology, types and results of major examination, treatment, complications and follow up plan _____

(e) Has the patient taken any home leave during this hospitalization? If yes, please state the date, time and reason _____

(f) Please provide reason(s) for hospitalization if this type of cases can be managed on day care _____

(3) Professional comment:

(a) In your opinion, was the hospitalized illness a recurrent episode or a chronic illness or related to a previous complaint/diagnosis? If yes, please provide date of the first episode and details _____

(b) Has the patient ever had the same symptoms before/has the patient been treated or hospitalized for these same symptoms before?
If yes, please state, to the best of your knowledge, on a separate sheet when and describe details (including a brief summary describing the onset date, duration of signs and symptoms, disease, etiology, types and results of major examination, treatments, complications and follow up plan) _____

(c) Was the condition due to or associated with the following (please circle the right answers)?
Accidental bodily injury, abuse of drugs or alcohol, AIDS / HIV related illness, venereal disease or sexually transmitted disease, pregnancy, childbirth, miscarriage, abortion, infertility or sterilization, correction of vision, refractive error, cosmetic or plastic surgery, mental or nervous disorder, congenital condition heredity condition, developmental condition, suicide, attempted suicide, ionizing radiation, self-inflicted injury, participation in any sports, general check up or vaccination or none of the above.

(e) If you are referred by another doctor, please provide the referring doctor's full name and address _____

I hereby certify that all information given above is accurate and true to the best of my knowledge

Name of attending doctor / surgeon / qualification _____	Signature of attending doctor / surgeon with practice / hospital stamp _____
Date _____	Address and telephone no _____